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# The Individual Mandate — An Affordable and Fair Approach to Achieving Universal Coverage

Linda J. Blumberg, Ph.D., and John Holahan, Ph.D.

Some of the most prominent shortcomings of the U.S. health insurance market are rooted in the fact that the system is a voluntary one. Outside the state of Massachusetts, which recently instituted broad-based health care reform, no one under the age of 65 years is required to obtain health insurance coverage of any kind. Voluntary insurance markets have led to a system centered on segmenting health risk instead of one whose primary mission is ensuring affordable access to necessary and efficiently provided high-quality medical services. But the past need not be prologue. The orientation of our system and the distorted incentives that it creates can be changed. A vital component of such a change would be bringing all U.S. residents into our health insurance system through an individual mandate.

Health insurers engage in many practices that make it difficult for people with health problems to obtain and maintain their coverage; they do so for the express purpose of protecting themselves from the potentially enormous financial consequences of adverse selection. Adverse selection entails the disproportionate enrollment in insurance plans of people with higher-than-average health risk. There is a natural tendency for such selection to occur, because people prefer to pay for coverage only when they think they will need health care services. Insurance pools cannot be stable over time, nor can insurers remain financially viable, if people enroll only when their costs are expected to be high. Consequently, insurers create, and regulators permit, structured barriers against such behavior, including such policies as exclusion periods for coverage of preexisting conditions, benefit riders that permanently exclude particular types of care, higher premium rates or cost-sharing requirements for people with health problems, and outright denials of coverage.

If we required that every person obtain at least a minimum package of health insurance benefits — that is, issued a so-called individual mandate — we would eliminate adverse selection, and these barriers would become unnecessary and, in fact, indefensible. Remove them, and being in bad health would no longer prevent people from obtaining adequate coverage. But allow some opportunity for people to remain uninsured, and the straightforward argument for removing the barriers quickly evaporates. At that point, the only mechanism for creating equity in the health insurance system regardless of health status would be government subsidization of the cost of adequate, guaranteed coverage using a revenue source unrelated to the decision to buy coverage (e.g., income surtax, sales tax, or other general revenue base). Because any guaranteed source of coverage in a nonuniversal system would attract a high-average-cost population, the amount of new government revenue required for subsidizing the "excess" risk in this way would be very large.

Aside from creating barriers to adequate coverage and consequently barriers to obtaining necessary care, the voluntary insurance system has also distracted insurers from developing incentives and mechanisms for efficiently managing health care costs. Because total health care expenditures are so concentrated — the most expensive 5% of the population accounts for half of aggregate health care spending, whereas the bottom 50% of spenders account for only 3%[1] — the gains to insurers of avoiding the sick outweigh any possible gains from managing their care. As a consequence, resources have been devoted to such avoidance at a direct cost to effective care management. National health care costs continue to grow at rates well above inflation, but there has been precious little incentive for the private sector to devote its innovative energies to controlling them. And identifying ways to provide care more effectively and efficiently to people with serious medical needs is the only path to achieving the savings we all seek, since it is on such care that the bulk of the system's dollars are spent.

Although the shortcomings of the system for the high-cost population are many and well documented, most people who are excluded from the current health

insurance system have low incomes. Two thirds of the uninsured have incomes below 200% of the federal poverty level (100% being $10,830 for an individual and $22,050 for a family of four in 2009).[2] With the average employer premium today running approximately $4,800 for an individual and $13,300 for a family (with estimates based on average premiums for 2006 with adjustment for inflation[3]), such an expense would amount to 22 to 30% of income for those at 200% of the poverty level — much too high to be considered affordable. For people with lower incomes, such expenses would be even more crushing. As a consequence, the inclusion of everyone in the health insurance system will require substantial government subsidies to Americans with modest incomes. Without such assistance, a requirement to participate in coverage would be unfair and unjustifiable. A requirement for all to enroll in coverage must therefore carry with it a government commitment to make adequate coverage affordable at all income levels.

Substantial government resources — approximately $43 billion in 2008 — are currently devoted to supporting a minimal level of health care services for the uninsured. The federal government provides disproportionate-share hospital funds to safety-net hospitals through Medicare and Medicaid, and state and local governments provide varying levels of funding for uncompensated care. Care provided in this way varies considerably by locale and does not amount to continuous, comprehensive care for the uninsured, nor do all the uninsured have access to such publicly subsidized services. Once everyone has health insurance coverage, either public or private, these funds can be redirected to help finance a new system that includes income-related subsidies for care provided in efficient health systems. However, if the number of uninsured Americans remains substantial, it will be politically difficult to redirect these funds to support subsidies for insurance. And research leaves no doubt that without an individual mandate, many people will remain uninsured.[4,5]

The cost of subsidies will be relatively high, but most subsidies will go to benefit the poorest and sickest — those who are most likely to enroll on a voluntary basis. Thus, a mandate will tend to bring healthier people and those with higher incomes into the system at a relatively low incremental cost, as compared with a voluntary approach — and with the added benefit of government financing redirected from the programs that currently cover uncompensated care.

Enforcement of the mandate is the final issue. Once adequate subsidies exist, enforcement is essentially a matter of fairness to people who are playing by the rules. We believe enforcement through the tax system is the most efficient approach. Massachusetts is enforcing its mandate through a tax penalty equal to half the lowest available premium. We believe that those who do not enroll in a qualified plan should receive care when it is sought (as if they were enrolled) but should then have to pay back-premiums for the calendar year, plus a penalty, possibly as much as 25%. In our view, an enforceable individual mandate, with adequate subsidies and benefits, as well as a choice of plans, is the most politically feasible route to universal coverage in the United States today.

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**1.** Zuvekas SH, Cohen JW. Prescription drugs and the changing concentration of health care expenditures. Health Aff (Millwood) 2007;26:249-57.
**2.** The Urban Institute and the Kaiser Commission on Medicaid and the Uninsured. The uninsured — a primer: supplemental data tables. Washington, DC: Kaiser Family Foundation, 2008.
**3.** Medical Expenditure Panel Survey (MEPS). Rockville, MD: Agency for Healthcare Research and Quality. (Accessed June 11, 2009, at http://www.meps.ahrq.gov/mepsweb/data_stats/quick_tables_results.jsp?component=2&subcomponent=1&year=2006&tableSeries=1&tableSubSeries=CDE&searchText=&searchMethod=1&Action=Search.)
**4.** Blumberg LJ, Holahan J, Weil A, et al. Toward universal coverage in Massachusetts. Inquiry 2006;43(2):102-21.
**5.** Holahan D, Hubert E, Schoen C. A blueprint for universal health insurance coverage in New York. New York: The United Hospital Fund and the Commonwealth Fund, 2006.